SCHOOL OF
DENTISTRY
UNIVERSITY OF MICHIGAN

Community Based Clinical Education
1011 N. University Avenue
Ann Arbor, MI 48109-1078
T: 734.764.7389 F: 734.615.63387

Good Afternoon Chairman Shirkey and Committee Members,

Inadequate access to oral health care in the State of Michigan and other regions in the US persists for a variety of reasons, some of which include: maldistribution of providers throughout the state, inadequately funded health programs, patient's lack of understanding of the importance of oral health to overall health, and difficulty navigating the programs available to them, in concert with other social factors that prevent them from gaining access to quality oral healthcare.

Over the years the definition of a mid-level provider has been ever changing and evolving. At the University of Michigan School of Dentistry, our Community Based Dental Education model has proved to be a valuable resource for dental care in our state. We have been able to expand this program over the past 16 years with the help of supportive health care providers across the state, including private dental practices and Federally Qualified Heath Centers (FQHCs). Our students and partners have responded with a resounding endorsement of the benefits and opportunities created by this model and our growth in this program speaks to the demand for quality dental care. Providing critical and standard dental care to thousands of people from vulnerable populations at community clinics and health centers across the State is nothing new for the University of Michigan School of Dentistry (see appendix1).

Community-Based Dental Education (CBDE) has enhanced our students' dental education and has been increasingly incorporated into the curriculum to provide high quality and comprehensive dental care to underserved and Medicaid populations, while providing expanded practice experiences for students that influence their practice decisions upon graduation. Because of its unique design and proven accountability, the program has been recognized nationally by the American Dental Education Association, Delta Dental Foundation, the Michigan and American Dental Associations as well as other schools outside of Michigan. For example, the University of Oklahoma College of Dentistry and The University of Washington School of Dentistry recently adopted our model template for development of their community-based dental education program and Indiana University and University of California at Los Angeles School of Dentistry are currently reviewing this template for engagement of a CBDE program in their respective states.

All external sites including FQHC's and other organization types – Community Dental Clinics (CDC's), Tribal/Indian Health Service (IHS) Clinics, private practices and donated service programs – allow our students a diverse portfolio of clinical experiences and the program further allows our students to understand state (local), federal, and private funding mechanisms while enhancing access to care for underserved populations typically at or below 200% the poverty level, as well as disabled and homeless veterans and victims of human trafficking.

Results:
All models have resulted in "Win-Win-Win-Win" outcomes.

- Win for the underserved communities and their constituents who experienced increased access to quality care,
- Win for the FQHC's who experienced increased and more consistent productivity and recruitment and retention of oral healthcare providers,
- Win for the students who increased their clinical skills and broadened their experience base, and
- Win for our students by proudly showing an ethic of caring in communities throughout our state

The CBDE program at the University of Michigan School of Dentistry has gradually expanded over time to accomplish 2 goals:

1. To provide quality service to underserved populations in the State of Michigan, while enhancing the students' education, and
2. To change student attitudes and create value regarding public health service careers by providing students with immersion experiences in public health clinics.

Overall, student clinical experiences are robust and ACCOUNTABLE. Our sites have noted a significant increase in recruitment of recent graduates as practitioners, thus helping to solve a chronic manpower problem. Accountability is built into our online assessment program - which provides a platform for assessment of the sites as well as assessment of the student performance and productivity and impact. These positive experiences have resulted in approximately 8-17 % of the graduating classes since 2006 choosing public health clinics as their first choice for employment after graduation, with an astounding 21% or 24 of 114 graduates in the class of 2016 alone (See Appendix 2). The American Dental Education Association stated that last year the national average for all schools was only 2%. Here in the state of Michigan, as a result of our program's success, several FQHCs have expanded to multiple locations. This exemplifies the long lasting impact of this program. (See Appendix 3).

Another UM Study also demonstrated an increase in graduate dentists' confidence in providing care to underserved populations and a willingness to provide that care in their practice, upon completion of our program. The success of the CBDE program paved the way for us to create our new Interprofessional Care (IPC) model in collaboration with other units on campus (medicine, nursing, and pharmacy), a capstone IPC experience, to prepare our graduates for the future of healthcare. Evidence from similar endeavours in medicine suggests this approach will significantly impact the quality of healthcare provided to underserved communities throughout the state of Michigan.

If there are available resources, please consider investing in proven educational programs that will support licensed dentists to succeed, instead of creating another new healthcare provider. There is untapped capacity to serve the underserved and Medicaid populations in our model.

Over the last 16 years the School of Dentistry has allied itself with various organizations throughout Michigan. We are familiar with all oral health delivery models that treat Medicaid populations and have a keen understanding of the challenges they face and the competition of the funding mechanisms that all organizations rely upon whether it be local, state, or federal monies.

The UMSOD has proven that organizations that embraced the academic thread by partnering with us have witnessed outcomes that are more predictable and more productive. As our assessment tools continue to be refined we will continue to enhance our clinical sites not only in the oral heath arena but also total patient well-being because of the IPC immersion experiences. We understand the immense pressure that the Michigan Department of Community Health (MDCH) faces because of the competition regarding financial resources. The School of Dentistry has substantial information regarding the treatment of Medicaid patients and can continue to share this information with all organizations that have affiliations with our University.

The vision is to develop a universal template for seamless integration at host healthcare sites and to collect data in a centralized process. Our goal is to continue assessing, improving, evaluating outcomes of care, enacting change to improve care, and disseminating this information to all sites that accept students as part of their healthcare delivery team. The result is better and timely patient care in a more efficient and cost saving structure.

Personally, as a dentist, I am opposed to a lesser-trained individual performing irreversible procedures, especially on our most vulnerable patients. Over 11,000 patients of the 22,000 patients our students treated last year are by CMS (Centers for Medicare and Medicaid Services) definition, "special needs patients," These patients need and deserve oral healthcare provided by a healthcare professional who is trained to safely and effectively provide services within the full scope of general dentistry, and is also trained to provide care for a diverse patient population with special needs, which are over-represented in the populations with most limited access to dental care.

There are 2 dental schools, 12 dental hygiene programs schools and 9 dental assisting programs in our State. A better way to address this issue is to utilize the existing schools, the current workforce, and available clinics. These schools are a pipeline for increasing capacity especially in the public health centers. At the most recent MDA annual session, presentations were given to dentists regarding programs and relationships that can be developed to provide care and increase access.

Finally, the Pew Report states "Simply producing and maintaining a supply of oral healthcare professionals does not improve access to care when structural and environmental factors impose barriers." Through my travels in our state and through our cloud-based assessment of clinic operations, we have demonstrated that our students are willing to work in underserved areas when they experience a clinic model that is well managed. This trumps all, unfortunately, not all public health clinics are operating at peak efficiency but those clinics that have embraced an academic thread have benefitted from our relationship and our students have benefitted as well as the public we serve. It will take our on-going mutual efforts to provide critical healthcare to the residents of Michigan.

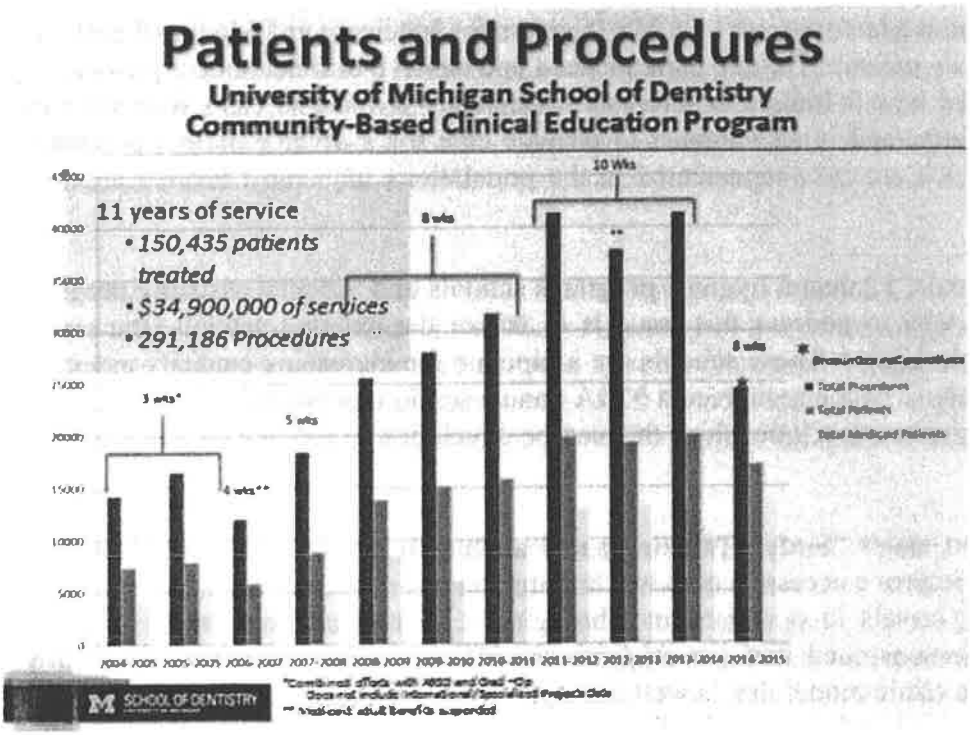
I would be happy to discuss any questions or clarifications you may have.

Thank you for your consideration.

Sincerely,

W.A. Piskorowski, D.D.S.
Asst. Dean of Community-Based Dental Education
Clinical Associate Professor
Department of Cariology, Restorative Sciences and Endodontics
University of Michigan School of Dentistry
1011 N. University (Dent 1205)
Ann Arbor, Michigan 48109-1078
cell: 734.353.9502
office: 734.764.7389
wapdds@umich.edu

Appendix1



(Appendix 2)

Community-based clinics as student first career choice compared to the number of weeks spent in outreach rotations from 1998-2010

	Weeks Spent in Outreach	Community Clinic	AEGD GPR Program	Higher Education	Other Clinic Type	Percent of Graduates Choosing Community Clinics
1998-2000	0	*	*	*	*	1.7%
2005	3	6	29	18	39	6.1%
2006	3	6	24	23	42	6.1%
2007	4	6	20	17	55	4.7%
2008	5	7	30	23	44	5.6%
2009	8	13	35	20	38	11.8%
2010	8	18	28	11	46	16.5%

M SCHOOL OF DENTISTRY

(Appendix 3)

Seniors' Immediate Plans After Graduation by Race/Ethnicity, by Percentage of Total 2014 Respondents

Immediate Plans	American Indian or Alaska Native	Asian	Black or African American	Hispanic or Latino	Native Hawaiian or Pacific Islander	White	Two or More Races	Non-resident Alien	Do Not Wish to Report/ Unknown
Private Practice/Dental	33.3%	46.6%	34.2%	41.5%	50.3%	46.0%	35.6%	60.8%	44.3%
Faculty / Staff/Member at a Dental School	0.0%	1.2%	1.0%	1.7%	0.0%	0.3%	0.0%	1.9%	1.3%
Armed Forces	6.7%	4.0%	4.5%	4.6%	16.7%	6.5%	11.9%	0.9%	3.8%
Other Federal Service (i.e. VA)	6.7%	1.1%	1.0%	1.7%	0.0%	1.4%	4.0%	0.9%	1.3%
State or Local Government Employee	6.7%	1.2%	1.0%	1.7%	0.0%	1.0%	3.0%	0.0%	1.3%
Public Health Commissioned Corp	26.7%	1.7%	2.5%	3.3%	0.0%	1.8%	1.0%	1.9%	0.0%
Dental Graduate Student / Resident / Intern	33.3%	34.8%	49.2%	34.8%	21.1%	34.2%	33.3%	20.0%	36.7%
Other Type of Student	0.0%	1.1%	0.0%	1.1%	0.0%	0.5%	0.0%	3.0%	2.0%
Other Position Related to Dentistry	0.0%	2.1%	2.2%	1.1%	0.0%	1.3%	0.0%	4.3%	0.0%
Unsure	0.0%	3.5%	3.5%	3.5%	5.3%	2.0%	3.4%	4.3%	5.1%

Note: Percentages may not total 100% due to rounding

United Voice article, in Michigan, approximately 90% of dentists are Caucasian; 3% are African American or Asian; and only 1% each are American Indian/Alaskan Native or Hispanic.